ASSEMBLY BILL No. 698

Introduced by Assembly Member Corbett

February 24, 1999

An act to amend Section 1371 of the Health and Safety Code, and to amend Section 10123.13 of the Insurance Code, relating to claims.

LEGISLATIVE COUNSEL'S DIGEST

AB 698, as introduced, Corbett. Insurance: claims: reimbursement.

(1) Existing law requires a health care service plan to reimburse an uncontested claim within a specified time limit, and if the claim or a portion of the claim is contested because further information is needed and requested, then the health care service plan has a specified number of days to reconsider the claim after receipt of the additional information. A violation of this provision is a crime.

This bill would require the health care service plan to reimburse the contested claim within the reconsideration time period if the claim is not denied, thereby creating a new crime and a state-mandated local program.

(2) Existing law requires a disability insurer to reimburse a claim within a specified time limit unless the claim is contested or denied.

This bill would require a contested claim based on the need for further information to be reconsidered within 30 days of the insurer receiving the additional information, and to be reimbursed during that 30 days if the claim is not denied.

(3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1371 of the Health and Safety Code is amended to read:

1371. A health care service plan, including a specialized health care service plan, shall reimburse claims or any portion of any claim, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan, unless the claim or portion thereof is contested by the plan in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

If an uncontested claim is not reimbursed by delivery to the claimants' address of record within the respective 30 or 45 working days after receipt, interest shall accrue at the rate of 10 percent per annum beginning with the first calendar day after the 30- or 45-working-day period.

For the purposes of this section, a claim, or portion thereof, is reasonably contested where the plan has not received the completed claim and all information necessary to determine payer liability for the claim, or has

not been granted reasonable access to information concerning provider services. Information necessary to determine payer liability for the claim includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the plan to determine the medical necessity for the health care services provided.

If a claim or portion thereof is contested on the basis that the plan has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided pursuant to this section, then the plan shall have 30 working days or, if the health care service plan is a health maintenance organization, 45 working days after receipt of this additional information to complete reconsideration *and, if the claim is not denied, reimbursement* of the claim.

The obligation of the plan to comply with this section shall not be deemed to be waived when the plan requires its medical groups, independent practice associations, or other contracting entities to pay claims for covered services.

SEC. 2. Section 10123.13 of the Insurance Code is amended to read:

10123.13. Every insurer issuing group or individual policies of disability insurance that covers hospital, medical, or surgical expenses, including those telemedicine services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse claims or any portion of any claim, whether in state or out of state, for those expenses as soon as practical, but no later than 30 working days after receipt of the claim by the insurer unless the claim or portion thereof is contested by the insurer, in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the insurer. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

If an uncontested claim is not reimbursed by delivery to the claimant's address of record within 30 working days after receipt, interest shall accrue at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period.

For purposes of this section, a claim, or portion thereof, is reasonably contested when the insurer has not received a completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine liability for the claims includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the insurer to determine the medical necessity for the health care services provided to the claimant.

If a claim or portion thereof is contested on the basis that the insurer has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided pursuant to this section, then the insurer shall have 30 working days after receipt of this additional information to complete reconsideration and, if the claim is not denied, reimbursement of the claim.

The obligation of the insurer to comply with this section shall not be deemed to be waived when the insurer requires its contracting entities to pay claims for covered services.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition

of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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